Intensive Care Management
DDS Collaboration

HUSKY HEALTH
CONNECTICUT

Intensive Care Management Overview

Intensive Care Management (ICM) is a voluntary person-centered program developed to support HUSKY members in reaching their health goals through education and access to quality healthcare. Derived in part from national case management standards of practice, the ICM Program which is offered through Community Health Network of CT, Inc. (CHNCT) consists of:

- Goals
- Regionalized Teams
- ICM Model
- ICM Process

ICM: Promoting Healthy Outcomes

Many factors can impact a person's ability to successfully manage his or her health, including:

Physical ***Behavioral*** ***Cultural***

Social ***Financial*** ***Environmental***

The ICM team recognizes that members can present with complex needs and barriers that place them at a higher risk for poor health outcomes. Utilizing a culturally aware and person-centered approach, the ICM Program strives to minimize these barriers.

ICM Program Goals

ICM promotes wellness and preventive care by providing care coordination to medically complex and behavioral health “at risk” HUSKY Health members.

Our goals are to:

- Identify and meet member needs;
- Promote health and wellness;
- Empower members in the self-management of their wellness; and
- Partner with providers to facilitate effective transitions of care.

These goals are achieved when members receive the *right care, at the right time, at the right place*.

ICM Regionalized Teams

ICM employs multidisciplinary care teams to cover all 5 regions of Connecticut. These teams consist of trained staff with the following titles:

- Nurse (RN, LPN, APRN and Wound Care)
- Certified Specialty Educators (Diabetes, Childbirth)
- Registered Dietitians
- Non-Licensed Administrative Care Coordinator (Non-clinical support staff)
- Medical Social Worker / Social Service Coordinator
- Community Health Workers
- Medical Director
- Pharmacy Consultant

Conditions Managed By ICM

ICM's specialized care teams address the unique needs of members with:

- Multiple unstable conditions (coronary heart disease, heart failure, COPD)
- Medical and behavioral health needs (SPMI – Serious and Persistent Mental Illness)
- Chronic diseases such as:
  - Asthma
  - Diabetes
  - Sickle Cell
- Transplants
- Maternity and newborn needs
- Children and youth with special healthcare needs
- Unmet social/community resource needs

ICM Model

ICM uses an individualized approach to provide support and education to HUSKY members based on their specific needs.

- Face-to-Face outreach:
  - ICM meets members where they are: home, shelter, hospital (inpatient, ED), skilled nursing facility, provider office, community setting
- Telephonic support
- Documented ongoing assessment of member needs
- Person-centered care planning, utilizing evidence-based clinical guidelines
- Culturally and linguistically appropriate services that take into consideration the member's beliefs and traditions that may impact self-management such as diet and provider selection

ICM Process

ICM's five-step process is designed to identify members and work with them to achieve their health goals.

ICM Process

Step 1: Member Identification

Q: How does a member access ICM?

A: There's no wrong door.

HUSKY members can connect with CHNCT's ICM program through various means.

ICM Process

Step 2: Comprehensive Assessment and Care Plan

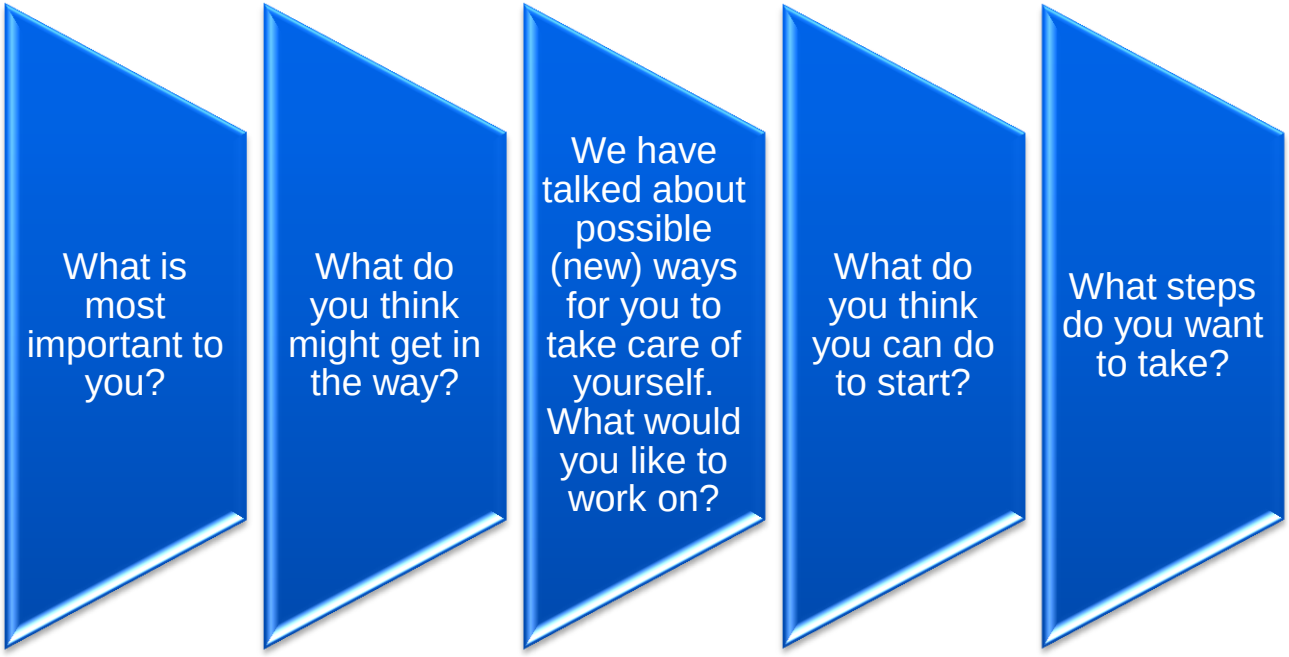
The components of an ICM Comprehensive Assessment include the following topics, which are addressed with the member/head of household (HOH):

- Adequate food, safety, and shelter
- Identification of member's strengths and barriers to care
- Depression screening
- Domestic violence screening
- Stress levels
- Self-care abilities (functional)
- Medication - understanding, safety, and willingness to take
- Provider access and engagement
- Health literacy
- Self-care understanding and adherence to the care plan

ICM Process

Step 2: Comprehensive Assessment and Care Plan (continued)

The ICM Comprehensive Assessment initiates care planning with the member, provider, and anyone from the member's support system that he/she wishes to include. The Care Plan promotes the member's choices, and focuses on needed services and goal-setting. The Care Plan addresses the following questions:



ICM Process

Step 3: Coordination and Collaboration

ICM coordinates care for the member by utilizing various resources, and collaborates with multiple organizations to provide support services.

Coordination

- Primary Care Providers (PCP)
- Specialists
- Federally Qualified Health Centers (FQHC)
- Behavioral Health Services
- Hospital Discharge & Homecare
- Durable Medical Equipment
- Inpatient/Outpatient Rehabilitation Services
- Dental
- Transportation
- Community Resources

Collaboration

- Family/Designated Caregivers
- Healthcare Providers-Physical and Behavioral Health
- State Agencies
- Waiver Program Administrators
- Community Support
  - Community Action Agencies
  - Supportive Housing
  - 211 InfoLine/Child Development InfoLine
  - Advocacy and Charitable Agencies
  - Aging and Disability Resource Centers

ICM Process

Step 4: Coaching and Education

ICM works with the member to provide the information needed for the member to become self-reliant.

Chronic Condition Coaching

- Knowing Numbers (blood pressure, blood glucose, cholesterol, weight, peak flows, etc.)
- Knowing Targets and Triggers
- Action Planning (*"What would you do if…?"*)
- Knowing Who to Call and When

Preventative Care Coaching

- Knowing the "When, Where, and Why:"
  - When do you schedule
  - Where do you call / go
  - Why is it important
- Well-Care Visits
- Screenings
- Immunizations/Flu Shots
- Dental and Vision

ICM Process

Step 5: Care Plan Goals Met

An ICM member case is closed when:

- The member, caregiver, and provider agree that the member's healthcare goals have been met.
- The member/caregiver:
  - Demonstrates self-advocacy
  - Expresses understanding of appropriate care and resources
  - Successfully manages his/her condition(s)

Upon Case Closure in ICM, members are informed that:

- They can seek ICM services for changes in their health status or condition(s).
- They have continued access to other services, including:
  - 24/7 Nurse Helpline
  - Health reminders
  - Appointment scheduling assistance (medical, dental, transportation)
  - Community Support Services

Case Study - 1

Clinical Summary:

- 27 year old female lives with father (mother deceased)
- Member attends a day program Monday - Friday
- Father pays privately for additional assistance to work with member after the day program and on weekends:
  - Works on activities to increase member's social skills
  - Assists with personal hygiene including showering (member is uncomfortable with Dad assisting with personal hygiene activities)

- Request received by Department of Developmental Services (DDS) Care Manager (CM) from member's father for additional Home Health Aide (HHA) services to assist with personal hygiene on private aide's days off.

Case Study – 1 (cont'd)

ICM Interventions:

- Outreach to DDS CM
- Outreach to member's father to explain and offer the ICM Program
  - ICM assessed member for unmet needs during the interview with member's father
- Outreach to PCP
- Outreach to multiple home health agencies for HHA services

Services for additional HHA services were successfully set-up following collaboration with home health agency and the PCP.

Outcome:

Member's father declined member's enrollment into ICM Program; acknowledged requested services were being provided by the home health agency. Member's needs were being met.

Case Study – 2

Clinical Summary:

- 24 year old male lives with parents
- History of cerebral palsy, autism and intellectual disability
- Member on Individual and Family Support Waiver; attends day services (29hrs/week)
- Member was receiving additional HHA services in home to assist with AM and PM routine until 8 p.m.
  - Parents had been putting member to bed at 10 p.m. until their own health issues made this impossible
- DDS referred member to ICM for assistance with obtaining additional HHA services

Case Study – 2 (cont'd)

ICM Interventions:

- Multiple and frequent outreach to member's father (HOH) to:
  - Assess member's care needs;
  - Update HOH on progress obtaining additional services;
  - Explain and offer ICM Program.
- Multiple and frequent outreach to:
  - DDS Care Manager to collaborate on needs and discuss progress on HHA services;
- Collaboration with CHNCT Prior Auth Department to assist with facilitating change in HHA provider;
- Outreach to PCP office to assist with smooth transition to new HHA provider;
- Outreach to new HHC agency to facilitate transition of case from prior Home Health Care (HHC) agency.

Outcome:

Efforts resulted in successfully scheduling a new HHC agency to meet the member's needs; however, prior to the new agency completing their intake visit, member was permanently placed in group home.

ICM Referral Process

Providers can refer members to ICM through the following methods:

ICM Referral Form: download from www.huskyhealth.com. Click on "*For Providers*," "*Provider Bulletins & Forms*," then "*ICM Referral Form*"

By Phone: 1.800.440.5071, extension 2024

By Fax: 1.866.361.7242

Key Contacts for CHNCT Medical ASO

Provider Call Center	
Telephonic Support	800.440.5071
Fax	855.755.0855
Intensive Care Management (ICM) Referrals	
Telephonic Referrals for ICM	800.440.5071, extension 2024
Fax Referrals for ICM	866.361.7242

Intensive Care Management Program

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Questions/Comments